RI MEDICAL ASSISTANCE PROGRAM PHARMACY CLAIM FORM

								PLEASE TYP	PE OR PRINT CLEAF	RLY. O	NL	Y BL	ACK O	R BLUE		N BE PROCESSI	ED.			
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											RETURN ORIGINAL TO:				THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE, I UNDERSTAND THAT PAYMENT OF THIS CLAIM WILL BE FROM FEDERAL AND					
											PHARMACY CLAIMS ELECTRONIC DATA SYSTEMS					STATE FUNDS AND THAT ANY FALSIFICATION OR CONCEALMENT OF A MATERIAL FAC MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS.				
													OX 200 VICK, R	5 I 02887		PROVIDER				
															SIGNATURE DATE					